THE JOURNAL

OF THE NEW MEXICO MEDICAL SOCIETY

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DR. G. S. McLandress, Editor-in-Chief, Albuquerque.

Associate Editors

Dr. F. T. B. Fest, Las Vegas
Dr. W. W. Phillips, Roswell
Dr. J. H. Wroth, Albuquerque
Dr. R. E. McBride, Las Cruces

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EDITORIAL

Through the efforts of Dr. C. M. Yater, Secretary of the Chaves County Medical Society, the following rates on all lines of transportation entering Roswell have been secured:

Over the Santa Fe Ry., one and one-fifth fare for round trip.

Over the Rock Island Ry., one and one-fifth fare for round trip.

Over the Santa Fe Central Ry., one fare for the round trip.

Over the Roswell-Torrance Auto Line, one and one-half fare, or $15.00 for round trip.

Tickets on all roads are sold on the certificate plan. Purchase one full fare ticket to Roswell only, being careful to get receipt for money paid for same. This receipt is countersigned by your secretary at Roswell, and upon presentation at ticket office you will be given a return trip ticket for one-fifth fare.

Permission to use the private automobile road between Torrance and Roswell has also been secured for those who wish to go overland in touring cars, but the management requests that, should the road be wet, the mail car leaving Torrance at 5:30 a. m. be allowed to pilot the private cars to Roswell.

Those who desire to make the trip in this way will please keep the above request in mind.

No charge for the use of the road will be attached.

The next annual meeting of the New Mexico Medical Society will be held at Roswell, Wednesday and Thursday, September 15th and 16th.

The Committee on Arrangements and the entire membership of the Chaves County Medical Society have exerted every effort to make the coming meeting successful and enjoyable from every standpoint.

This will be the first meeting ever held at Roswell, and from all indications the attendance will be very large. The scientific program covers a great variety of subjects, all of which will no doubt be enthusiastically discussed. A preliminary sketch of this program follows.

The secretary would again call your attention to the fact that the New Mexico Medical Society is the only door to membership in the American Medical Association for physicians in the Territory. Every regular physician in the Territory should join us. Application blanks will be gladly furnished to all who ask for them.

THE ROSWELL MEETING.

Will you help to make it a good one?
We have a good program.
We meet in a good place.

Make it a good meeting by helping to secure a good attendance, by being at every session on time, by taking part briefly in discussions, by seeking in every action taken by the Society the highest welfare of the citizens of our Territory, and thereby maintain the honorable record of the New Mexico Medical Society; lastly, but not least important, by bringing the ladies with you.

The Grand Central Hotel, Roswell, which will be headquarters, and at which our banquet will be held, makes a special rate of $2.00 per day to the visiting physicians and their wives.

PRELIMINARY PROGRAM FOR THE ROSWELL MEETING, N. M. MEDICAL SOCIETY SEPT. 15-16, 1909.

"Pseudoleukemia," Dr. B. F. Stevens, El Paso, Texas.

"Infantile Scorbutus," Dr. C. E. Lukens, Albuquerque.

"Pelvic Inflammation," Dr. A. H. Faith Clovis.

"Otetis Media," Dr. T. E. Pressley, Roswell.

"Milk Sickness," Dr. C. F. Montgomery, Roswell.

"The Indigent Consumptive," Dr. C. M. Mayes, Roswell.

"Ectopic Gestation," Dr. H. A. Ingalls, Roswell.

"Use and Abuse of Surgery," Dr. W. C. Buchley, Roswell.

"Saline Transfusion in the Treatment of Ilio-Colitis," Dr. C. F. Beeson, Roswell.

"Treatment of Typohid Fever in Private Practice," Dr. L. H. Pate, Lake Arthur.

"Medical Aspects of Life Insurance," Dr. F. de la Vergne, Albuquerque.

"Treatment of Cystitis," Dr. James Vance, El Paso, Texas.

"Notes on 128 Consecutive Cases of Appendicitis Treated with Continuous Irrigation, etc.," Dr. Geo. C. Bryan, Alamogordo.

"Vesical Calculus" (with exhibit of specimens), Dr. J. W. Colbert, Albuquerque.

"The Careful Practice of Obstetrics," Dr. C. D. Ottosen, Willard.

"The Practicing Physician and His Care of the Consumptive," Dr. J. W. Laws, Lincoln.

"Hay Fever," Dr. J. W. Tinder, Roswell.

"Physical Diagnosis of Tuberculosis," Dr. J. W. Kinsinger, Roswell.

"Septic Infection of the Uterus and Adnexa," Dr. D. H. Carns, Albuquerque.

"Fallacies of Methods of Staining the so-called Bacillus Tuberculosis," Dr. F. T. B. Fest, East Las Vegas.

"Eye Strain; Its Diagnosis and Treatment," Dr. Frank E. Tull, Albuquerque.

"Preliminary Report on the Hypodermic use of Mercury in Tuberculosis," Dr. LeRoy S. Peters, Silver City.

"Peritonitis," Dr. S. D. Swope, Deming.

A CONVENIENT CHLOROFORM PACKAGE.

Much interest is being manifested in the chloroform dropper-ampoule marketed by Parke, Davis & Co., and which, in the opinion of a good many physicians and surgeons, is the most conveneint and practical chloroform package that has ever been introduced to the profession The new device is at once a hermetically sealed container and a perfect dropping-bottle that can be carried about in the emergency bag at all times in readiness for immediate use. It supplies in portable form enough of the anesthetic for one service —about thirty grammes. The desirability of such an individual package and its superiority over the ordinary amber, cork-stoppered bottle heretofore supplied is appreciated when one remembers that chloroform in broken packages rapidly deteriorates under the influence of air and light and becomes contaminated with chlorine decomposition products.

The dropper-ampoule is, furthermore, a very economical package, as loss by evaporation, spilling of contents, and deterioration are practically eliminated. The chloroform may be dropped directly upon the mask with ease and accuracy. The anesthetist has perfect control of the outflow and is enabled to regulate at his discretion the intervals between drops.

Physicians desiring further information relative to the dropper-ampoule are advised to write to Parke, Davis & Co. for their illustrated circular descriptive of the new package, addressing them either at their main laboratories, Detroit, Mich., or any of their branches.

FRACTURES OF THE SKULL.*

By Dr. L. G. Rice, Albuquerque.

The skull may be said to be fractured in distinction to its being wounded, when as the result of a blow it becomes cracked or broken into more or less separate pieces.

This injury is classified admirably by Keen, from whom most of this paper is taken.

Depending on the mechanical factors at work in their production, they are distinguished as bursting fractures and fractures due to local depression or indentation.

Fractures are open or compound when the overlying soft parts are destroyed. They are simple or closed fractures when the soft tissues covering them remain intact. According to their form they are distinguished as linear or fissured, that is where the bone is simply cracked without displacement. Where the sutures are only separated they are called fractured by diastasis. Comminuted or fragmental fractures are when the line of the fracture intersects so as to isolate separate pieces of bone. Depressed fractures when fragments of bone, whether of the entire cranial thickness or of the inner table alone are driven below their spherical level.

Perforating fractures or fractures with loss of substance are the result of punctured wounds as is the case in most penetrating bullet wounds.

According to their location they are classified as fractures of the base and fractures of the vault. Though they are separately classified, fractures of the base are generally a continuation of a fracture of the vault if not a continuation of a fracture elsewhere it is due to a force transmitted from another part. Fractures of the base are almost always linear and practically never displaced.

The Mechanism of Fractures.—Regarded as a hollow shell of bone which possesses elasticity sufficient to rebound when dropped, the cranium must needs differ from all other bones of the skeleton in the mechanism of its injuries. Certain of the physical laws which explain the peculiar form assumed by these injuries are known to us; others are still in dispute, and though, from a strictly clinical point of view, of chief importance is the knowledge that under certain conditions breaks occur in a certain manner and lead to certain complications, we naturally search for an explanation of the reason why they so occur, even though this information may in no wise effect our diagnosis, prognosis, or treatment.

We must take into consideration the double effect of the impact, for the blow may produce (1) disturbances which are direct and chiefly of local consequence, and (2) those which are indirect and lead to solutions of a continuity at a distance, setting aside for the moment its irregularities and considering the skull to be an elastic globe, an impact will momentarily lessen its diameter in line of the blow, and force nearer together the point or pole of impact and the point on the sphere diametrically opposite. As the impact forces the pole together it will at the same time bulge out the sides of the sphere and thus increase the equatorial circumference and, in a lesser degree, the circumference of all the other circular planes which lie perpendicular to the polar diameter. If the distortion following the impact is inconsiderable the skull, owing to the elastic rebound.

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* Read before Bernalillo County Medical Society, April 7th, 1909.

will resume its former shape unimpaired If the distortion, on the other hand, is so great as to overcome the molecular cohesion of the bony particles, they will be disrupted This may take place (1) as a rupture or bursting of the bone in parts remote from the poles of impact where cranial dimensions have been increased to the point of overcoming tensile strength of the particles, and (2) as a local indentation at the pole of impact where cranial dimensions have been diminished to the point of overcoming the local resistance of the particles to pressure. These two qualities of elasticity—tensile strength and resistance to pressure—have been the objects of special study by Rauber, who has shown that resistance to pressure is a third greater than tensile strength. This, however, does not mean that fractures are less likely to occur at the pole of impact than at a distance, for other factors come into play.

To illustrate: Not long since I had a case of a man who fell in getting off a street car which was going at a rapid speed. He received the full force of the fall on the external occipital protuberance, there was no fracture at this location or the other end of the pole, but an angry fracture running almost the entire meridian that passed over the vault in line of the sagital suture. Another case I had since was that of a young man who fell about eight or ten feet on a bed of small stones. The place of the impact was in the temporal region where there was a depressed fracture about the size of a 25-cent piece, no fracture at other pole or in any meridian connecting the poles, the injury being limited to the area immediately surrounding the pole of impact due to the thinness of the bone in this region. This all goes to show that the place receiving the blow and the character of the blow have a great deal to do with our diagnosis of the extent of the fracture previous to operation or autopsy.

We must remember that a blow from a body with a comparatively small surface, expends its force quickly and a rebound occurs before the form of the skull, as a whole, has been sufficiently altered to produce lesions at a distance. These fractures are usually on the exposed vault and they are the ones where the inner table only is fractured. On the other hand, blows received from a flat surface are prone to cause effect at a distance just as a concentrated one from a small body is apt to produce local effects. Most of the fractures of the base are caused from a diffuse blow, oftentimes very remote from the point of impact.

Mortality.—Disregarding the etiological factor, the patient's age and also the character of the injury, about one-third of all cases in the past have proved fatal, and as the fatalities are largely due to the immediate cerebral complications, modern methods of treatment have not served to greatly alter these figures. The percentage of fatalities increases with age,—the younger the individual the more favorable the outcome. Fractures of the base are commonly thought to be attended with a higher mortality than those of the vault, though with our improved diagnostic measures, (lumber puncture, for example) we may find that many cases of simple basal fracture have heretofore been overlooked and regarded merely as concussion—a fact which may make one's percentage of recoveries at least appear larger today. Excluding those cases which have died as an immediate result of the injury and those which have later succumbed to infection, the average duration of life in the fatal cases is said to be forty-four hours; so

that there is some basis for the old rule, adhered to by Gergmann and Wagner, that survival over two days gives a favorable prognosis.

Prognosis.—Is in no way proportionate to the extent of the cranial injury, but depends almost entirely to the ultra cranial lesion. An insignificant crack of base, associated with a focal hemorrhage in pons or medulla, may put a sudden end to life; whereas an extensive fragmentation of the vault which allows for considerable cerebral expansion, may actually save life through decompression. An insignificant punctured fracture which does not even produce concussion may prove fatal from meningitis or abscess later on; a comminuted and depressed compound fracture, on the other hand, may heal practically untreated and give few symptoms.

Diagnosis.—The diagnosis of fractures of the vault may offer difficulties particularly in the case of linear fissures and of those involving the inner table alone. One, however, is much more apt to be misled by the peculiar feel of the infiltrated edge of a subaponeurotic extravasation into making a faulty diagnosis than to overlook a cranial fracture when it is actually present. When the scalp is intact, linear fractures may at times be recognized through lines of tenderness on pressure, particularly over the temporal fossa, and by a changed percussion note if there is any paying of the fissure. In open wounds there should be no difficulty in recognizing even a closely approximated fissure, owing to the blood which oozes from between its edges; sutures, however, may be mistaken for fissures.

In fractures involving the base alone we must, in the long run, depend entirely upon the symptoms which we have learned to recognize as common accompaniments of these injuries rather than upon any direct evidence of the bony lesion.

Evidence from intracranial or extracranial bleeding, either free or into the tissues, is of particular value.

The intracranial extravasations usually take p'ace into the subdural space, owing to its close attachment, the dura is usually torn when the bones are fissured. The amount may be small or so extensive as to cause rapidly fatal compression. It may be recognized by finding evenly distributed red blood corpuscles in the cerebrospinal fluid withdrawn from lumbar puncture.

The extracranial extravasations may also be free, and bleeding may take place from the nose, mouth or ears, in case the ethmoid, the accessory sinuses, the eustachian tube, or the tympanic cavity have been implicated. It goes without saying we must exclude a bloody nose or ruptured tympanum. Ecchymoses is slow to appear. They are common in the orbit under the eyelids, or conjunctiva when the frontal plate is injured, and in fractures of the middle and posterior fossae they find their way to the surface over the mastoid process or down the neck after some days.

Complications are often an aid to diagnosis especially where certain nerves are involved.

Treatment.—Gun shot fracture itself is the least of the ills following cranial gunshot wounds and cannot be considered apart from the other complications. If there is a cleancut perforation and no serious immediate symptoms the wound may be left with a simple drain and healing may take place without incident; for unless septic foreign particles have been carried in with the missile, its track quickly cicatrizes and the bullet itself becomes encapsulated. If

there is a lacerated scalp and considerable local comminution of the skull it is advisable, after paring the edges of the scalp wound, to enlarge it by incision and to trephine the skull in order to readjust any depressed fragments, to evacuate clots, to relieve tension, and to afford better drainage. A large defect almost always leads to a hernia and perhaps to a fungus cerebri, owing to the swelling of the lacerated brain. Largely owing to this, drainage of the track of the bullet is a most unsatisfactory procedure, and one must usually be satisfied with a superficial drain down to the dura and brain, but not far into the latter. The temptation to probe for, to locate, and to extract deep-lying fragments of the bullet should be resisted by the surgeon; for even if successful in their object these procedures usually serve merely to increase the damage already done by the missile without conferring any benefit whatever from its removal.

The late complications must be met as are those due to cranial injuries from other causes, and here again it must be borne in mind that the paralyses and mental disturbances are not due to the presence of the foreign body, but to the cicatricial changes in the nervous tissue due to its passage through them, and that they consequently are the same whether the bullet has lodged, emerged, or been removed.

Treatment of Fractures Other Than Gunshot.—Again we are confronted by the insignificance of the fracture compared to the complications. In fracture of the vault the indications for surgical intervention are usually deformation of fragments. In fractures of base it is entirely different for here deformation is generally absent and intracranial complications are especially serious.

In compound injuries of the vault we may easily determine the form and estimate the consequences of the injury, and our endeavor should be to thoroughly cleanse the wound, to elevate depressed fragments, to restore a wound in the dura if one exists, and to leave the parts as nearly in their natural position as possible. If the fragments are depressed and wedged it may be necessary to trephine at the edge of the depression before they can be pried into place. Even in the absence of visible depression an opening may be required when cerebral symptoms are present, due to depression from the inner table alone or to intercranial hemorrhage.

It is another matter when injuries of vault are covered by intact scalp for there may often be great difficulty in determining whether there is sufficient justification to transform a simple into a compound fracture, but this is to be decided by the surgeon in charge.

The treatment of basal fracture resolves itself largely into treatment of contusion or compression of varying degrees, for which our therapy is largely restricted to rest, absolute quiet, an ice-cap, sedatives when headache is severe or when there is great restlessness, and to free evacuation of the bowels preferably with a saline—measures to be observed in practically all cases of cranial injury. The greatest care should always be exercised in handling and in transporting any case of fracture with intracranial symptoms for the symptoms are much aggravated by any form of jolting.

As for special indications for surgical interference and technique I would refer you to the various works on this subject.

Next meeting at Roswell, September 15-16, 1909.

ACUTE INTESTINAL DISEASES OF OF CHILDREN.*

By Dr. C. E. Lukens.

In presenting this paper as an introductory to our discussion of this important topic I shall not attempt to deal with all manifestations of diseased conditions of the intestinal tract, I will not enter into a discussion of the pathology of the diseases of which I do write, but name quickly some of the commoner forms met with in our practice and offer suggestions as to the etiology and symptoms and clinical course.

To be named in the acute intestinal diseases of children are, Acute intestinal obstruction, appendicitis, acute ptomaine poisoning, and Acute Catarrhal Enteritis.

The two latter forms will consume the brief time allotted to this paper.

Acute Ptomaine Poisoning.

When the case is presented of a child previously in good health, who has been seized with vomiting, with great prostration, or collapse, with diarrhoea probably but without abdominal pain in many cases, acute Ptomaine poisoning may be suspected.

The history of the child's having eaten, not always recently, of food consisting of tinned meat, fish or shell fish or sometimes alleged fresh fish one may have a clue to the nature of the illness and this will be corroborated if there is a story of other members of the family having been similarly attacked, although in elder members of the family the symptoms may have been so slight as not to have occasioned special notice.

The children on the other hand will present a case of marked symptoms which end in collapse and death.

Treatment.—Elimination. Stomach should be washed with warm saline solutions. Calomel, grs. 2-3 with a drachm each of Sulphate of Magnesia and soda may be introduced into the stomach, and salines continued until free purgation.

Patient should be kept in bed, surrounded with hot water bottles. Food should be withheld, but ice to suck, a little brandy or hot water. Hot fomentations may be applied to relieve pain if complained of. Opium should not be given, pain and restlessness may be relieved by Chloral Hydrate or Pot. Bromide. Stimulation by strychnine, adrenalin, digitalin or caffine.

Acute Summer Diarrhoea, or Enteritis.

Diarrhoea is the premonitory sign of acute intestinal disturbance in infancy and childhood.

It may arise in connection with a constitutional affection such as rickets, from an overloaded bowel, sometimes from excessive peristalsis caused of nervous origin.

Acute catarrhal enteritis may be caused by overfeeding, too frequent feeding or improper food, the condition is ofttimes apyroxial but if not checked or if the absorption of toxines has been rapid the temperature may rise quickly to a point very alarming to the family of the patient.

The acute summer diarrhoea or summer complaint is an affection, as the name implies of the hot season, the hot-

* Read before the Bernalillo County Medical Society, July 1, 1909.

ter the summer the greater is the prevalence and severity of this disease, it seems sometimes to be epidemic in character.

The cause of the disease may be laid to two sources, the prostration and debility caused by the excessive heat, and as I believe by the favorable conditions at this hot season for the growth of pathogenic organisms in the food supply, the rapidity with which fermentation occurs, and the entrance into the milk or other food stuffs of germ-laden dust and dirt and the direct introduction of disease germs through that worst of all enemies to the human race, the house fly.

The disease runs a very acute course, it may run for from four days to a week or the child may be in a moribund condition at the end of twenty-four hours.

The onset of the disease is usually sudden, but there may have been a disturbance of the gastro-intestinal tract for a few days before the trouble occasions alarm, the child becomes irritable and refuses food or vomits after each meal, the temperature rises and the diarrhoea becomes pronounced, the motions are watery and grey or greenish matter is in evidence, there is much mucus often blood stained. The stools are at first extremely offensive, there is a feeble and rapid pulse and the extremities are cold and blue, the constitutional disturbance is marked and the tissues seem to be shrivelling. Convulsions may occur or coma may come on quickly, the temperature may be very high or subnormal.

Preventive Treatment.—If the custom obtained in this country which is reputed to hold in China and the physician was only paid as long as his patient remained in health, and there could be some way devised to enforce proper care of infants by their nurses, many babies' lives would be saved. I coincide with the instructions given in the free lecture to mothers at the Paddington Green Children's Hospital in London, Eng. The following is also printed and given to homes by free distribution:

Instructions to Mothers and Nurses.

In hot weather milk quickly turns sour or becomes tainted by dust, dirt and flies and may easily bring on diarrhoea unless the following precautions are taken:

"Buy the cows milk twice a day, not once only—and get the best milk you can, as cheap milk is always dangerous.

Boil it at once for one or two minutes. Then place it in a covered vessel in a basin of cold water to keep it cool. The milk must be covered to prevent dust and flies from reaching it. Always taste the milk, in a spoon, before putting it in a bottle, to see that it has not turned sour. Do not put the nipple in your own mouth at all.

"Do not keep any milk which may be left in the bottle for the infant's next meal, use it for other purposes.

The bottle should be boat shaped with an India rubber nipple, but no long rubber tube.

The bottle should be scalded out after use, and cleaned with a bottle brush, which should be boiled immediately before using.

After each feed the nipple should be turned inside out and washed, and kept with the bottle in cold, or salt water.

Good milk is often spoiled by dirty bottles.

When fresh cows milk cannot be obtained, or the milk has turned sour, use the best sweetened condensed milk.

Get small tins, as after the tin is opened the milk will soon go bad.

"Cover an opened tin with clean mus-

lin or butter cloth to protect from the dust and flies and keep in a cool place.

In any case of sudden diarrhoea or vomiting stop the milk at once, give only plain water which has been boiled, or even barley water, and take the baby to a doctor without delay.

Do not think the diarrhoea will soon pass off. as the baby may be so ill in twenty-four hours that no treatment will be of any use.

Do not be afraid the baby will starve if only plain water or barley water is used for a day or two. There is no danger of this.

"Do not think when a baby cries or is sick that it only wants more food.

"In hot weather do not keep bones, stale vegetables or fruit, and other rubbish for the dust bin in the room or house. Burn as much of the rubbish as possible. Rubbish breeds flies, and flies poison the food they settle on."

I shall not continue this paper with suggestions as to the treatment beyond these words:

The further introduction of the poison into the system should be prevented. Food which will furnish a suitable media for the growth of the organisms should be withheld, the fact that this is an acute infectious disease should be recognized and care taken for the disinfection of the hands of the nurse and the vessels or cloths that come in contact with the stools.

The treatment should be evacuant and eliminative. The first object should be to remove the poison from the gastro intestinal tract and then to eliminate from the blood and tissues the organisms and toxins which found an entrance and set up the intestinal disturbance to be corrected.

Next meeting at Roswell, September 15-16, 1909.

HEADACHES.*

By Dr. J. A. Reidy, Albuquerque.

I propose in this paper to consider only headaches in which diffused pain in the head is the principal complaint of the patient. Headache is the name given to diffuse pain affecting different parts of the head and not confined to the tract of any particular nerve. Headaches are to be distinguished from neuralgias, and from head pain known as migraine. Headaches are diffused pains caused as a rule by irritation located in or referred to the perepheral ends of the fifth nerve. Their seat is usually within the skull.

Neuralgias, on the other hand, are caused by irritation of the ganglia, or trunks of the nerves. The pains are local and confined to single branches of the nerve. Migraine is a periodical neurosis in which there is an explosion of nerve force not only affecting fifth nerve, but other cranial nerves as well. It is a general disease of which the headache is only one symptom.

Headache is the most common of nervous symptoms. Twenty-five per cent of men and fifty per cent of women are subject to it more or less. Most cases of headache occur between the ages of eight and twenty-five, especially in females. Early childhood and declining years are particularly exempt from chronic and functional headaches.

Headaches may be classified in accordance with their location and the character of the pain. We have accordingly,—Frontal, occipital, parietal temporal, verticle, diffused, or a combination of any of the above. The kind of pain differs with different persons and with different causes.

In studying cases of chronic headaches it is always our first endeavor to

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* Read before Bernalillo County Medical Society, August 5, 1909.

obtain the most precise description as to location of the pain, character of the pain, spots of tenderness in the head, and if possible, find out at the time, the cause of the present attack. Then proceed to make a physical examination of past and present history.

First family history as to heredity, nervous tendencies, worries from business, etc. Personal habits as to care of diet, condition of bowels, menstrual function, as to what extent they use coffee, tea, tobacco, alcohol, occupation, amount of exercise, fresh air, etc.

Make examination of blood vessels, blood, urine, reflexes, eyes, teeth, ears, nose, pelvic organs, etc.

Headaches may be classified according to the cause under the following headings:

1st—Toxic, those due to ptomaine or leucomaine poisoning, Bright's disease, constipation and various intestinal disorders.

2nd—Neurasthenic or persons with a neurophatic diathesis.

3rd—Vaso motor congestive, arteriosclerosis.

Anemia—In anemia the patient often describes the sensation of fullness on top of the head, or a feeling as if the top of the head was going to come off. Anemia of the brain, as a rule, is a part of a general condition—of anemia and malnutrition. The headache may be verticle, frontal or diffused, and is often associated with syncope and dizziness. The pupils, as a rule, are dilated. The recumbent position relieves the headache, but it immediately returns on arising. In such a headache if the anemic condition is corrected the headache should leave.

Toxic headaches are most commonly described as involving the whole of the head, or as a tight band of pain encircling the head. The time of occurrence of toxemic headaches has some relation as to absorption of the poison.

The morning headache of men who have spent the night at a banquet and indulged too freely is readily cleared up when the cause is removed. Constipation is perhaps the most fruitful of all causes of headache, and it is all the more insidious because women become so habituated to the condition of sluggish bowels that they fail to realize the importance of its bearing upon their general health. Constipation is not incompatible with apparent health for some persons may be constipated for a week or more at a time without any complaint of digestive trouble or headache.

No doubt most physicians have seen patients, (domestic help, as a rule) consult them for some minor ailment and when questioned in regard to the bowels will have to figure back for a week or so or consult the calendar to be sure when they had the last action of the bowels. A great many people of this class seem to be immune from headaches. The higher up in the human scale we go the more susceptible people seem to headache of all forms.

Uremic headache due to renal disease is of very common occurrence. The pain is usually situated in the occipital region extending to the neck. It may be associated with somnolence, nausea, vomiting, and vertigo, simulating brain tumors. But an examination of the urine, the eyes and the heart as a rule will clear up the daignosis.

For relief of headaches caused by high arterial tension the different nitrites are of inestimable value. Nitro glycerine in grain 1-100 every three hours until the tension is relieved; sodium nitrate in ½ grain doses three times daily is an excellent remedy where the arterial tension is high from any cause.

Sometimes headaches occurring every day or every other day at about the same time will clear up by giving a few doses of quinine used in the same way as for malaria. You can generally get a history of malaria in the past.

Headaches caused from pelvic trouble in women—the headache occurring only at the time of menstruation is by no means necessarily due to any derangement of the pelvic organs. The most normal woman is more inclined to be nervous at that time and the resisting power is lowered. Retrodisplacement of the uterus posterior parametritis, polypi, subinvolution, prolapsed ovaries, adhesions, etc.

The pain is almost always verticle if due to disease of the body or endometritis. Occipital when due to retrodisplacement. The headache as a rule is worse during menstruation.

The occipital headaches of uterine and ovarian displacement are aggravated by walking or standing.

The stomach; hyperacidity, deficiencies of the normal acid, or the presence of food undigested from any cause. These headaches are frontal and bilateral as a rule. When such a headache is due to undigested food remaining in the stomach, it is quickly relieved by vomiting, or washing the stomach.

The teeth, especially decayed teeth in the upper jaw, the lower wisdom teeth on account of impaction at times, produce a headache which is unilateral. The upper first molar and second bicuspid by communication with the antrum of Highmore may become decayed and start an abscess in the antrum. The headaches in such cases are diffused covering the forehead and temples.

Nasal polyps may give the first evidence of their presence in the severe headaches they provoke. Mouth breathers or a difficulty in breathing, especially if marked at the time of the headache, should call for an examination of the respiratory passages.

Some patients date their headaches from an over-exposure to the sun or a slight sunstroke. The least exposure to rays of the sun or fatigue serves to bring on an attack afterwards.

The most persistent and distressing form of headache is that which occurs in patients with intracranial tumors. It is one of the most constant of symptoms, as a rule the headache is very severe and continuous. The headache exists even in delirium. This fact distinguishes it from the headache of fever which ceases in delirium.

In cerebral abscess headache is the earliest and most constant symptom, just as in brain tumor, but the pain is generally referred to the seat of the abscess.

Intracranial Syphilis. — Headache may antedate all other symptoms of intracranial syphilis for several months or a year. It often occurs in paroxyms or there are periodical exacerbations in which the pain becomes intolerable. Generally the pains are more severe toward evening or night and prevent sleep. Extreme tenderness on pressure upon the skull occurs only when the periosteum or bones are involved at the same time.

Treatment.

The most important element in the treatment of patients with headache being the recognition of the cause as the pain is more often dependent upon some underlying constitutional condition than intracranial disease.

In all forms of headache it is essential that the intestines be kept free from fecal accumulations and that the action of the digestive organs be regulated with a suitable diet. Headache from constipation is readily relieved by a brisk cathartic.

All supposedly reflex causes should

be removed as far as possible. Many patients seem to develop headache upon the slightest provocation, they seem to have an inherited predisposition. It is generally desirable that any existing error of refraction or eye muscle defect be corrected. Even when such conditions are discovered and remedied relief from the headache does not always follow. Operating upon the nose for deviated septum, removal of adonoids or nasal polypi will be followed by relief from a chronic headache.

Headaches due to cerebral congestion may be relieved by avoiding all forms of cerebral stimulation, mental or physical excitement, keeping bowels in good order by calomel and salines.

In severe cases you may have to resort to venesection. In headaches from anemia rest, iron and nutritious food. In most all forms of headache when called upon for relief the patient cannot wait for a systematic examination, they come for relief from distressing pain whatever the cause may be, then we have to resort to some form of treatment to give them temporary relief, or in other words, symptomatic treatment, which consists of different coal tar products, antifebrin, phenacetine, salicylicate of sodium, caffine, and sometimes morphine.

Phenacetine often needs to be given in large doses, 15 to 20 grains. Muriate of ammonia is very good but the dose is large, from 40 to 60 grains, well diluted. Menthol in doses of from 5 to 10 grains in hot water sometimes stops headaches. I was called to see a patient about one year ago who took two drachms of acctanalid at one time for relief of headache. She was very cyanotic with a rapid, thready pulse. I gave one-tenth grain of apomorphine, and one-fifteenth grain of strychnia sulphate hypodermically, and in a few hours she was as well as ever and assured me she had no headache.

In case of brain tumor it is good judgment to start a patient on antisyphilitic treatment and give them the benefit of the doubt as to possible gummatous growth. The operation of trephining the skull should be resorted to when all other methods fail, to relieve the pain.

DIAGNOSIS OF APPENDICITIS.*

By Dr. W. L. Bishop, Billings, Montana.

It is not, as is generally supposed, the want of a safe and proper treatment for appendicitis but, rather, a lack of ability to diagnosticate appendicitis itself which continues to render the complications of appendicitis a more or less hazardous undertaking.

Appendicitis, when treated by operation and removal of the Appendix Veriformis, does not, practically speaking, have any mortality.

The credited mortality in appendicitis is the mortality of the complications following appendicitis, rather than the mortality of the disease itself and is due, in my opinion, to the lack of a definite rule for the diagnosis of simple uncomplicated appendicitis, and the failure to remove the Vermiform Appendix in all of the cases of simple, uncomplicated diseases of that organ.

The published mortality of appendicitis is particularly misleading to the public and, in consequence, many cases presenting a condition for safe operation, are carried into an unsafe condition for the reason that the patient, or his lay brothers and sisters, have in mind some death following an operation for some complication of appendicitis, which was known simply as ap-

* Read before Montana State Medical Society at Butte.

pendicitis by the community and so labeled by the public press.

This publication by the press is never qualified and the public considers every case of appendicitis to be like every other case of appendicitis.

As I have intimated, these errors are for fatal procrastination in a very large number of cases.

The general practitioners have not been taught the proper way to diagnosticate this disease, except in its so-called typical type and presenting all of the many symptoms and physical signs of the disease while, as a matter of fact, the majority of the patients suffering from this affection have atypical symptoms and, with one exception, atypical physical signs.

In my experience of several hundred cases, I have found tenderness present in all of the cases and, yet, the general practitioner depends less upon this physical sign in making a diagnosis than upon any other symptom or physical sign.

Not only the general practitioner, but every attendant upon the sick, should be taught that tenderness is the only sign necessary to a diagnosis and that all cases presenting this tender appendix should have that appendix removed.

Not even a suggestion of any other treatment should be mentioned.

This tenderness can be elicited by very gentle palpation with the patient brought well over the right edge of the bed and counter pressure, with the thenar and hypothenar eminences of the right hand in the loin space.

By flexing the fingers, at first gently, and making pressure only during expiration and palpating with the palmar pulp of the fingers, there can frequently be appreciated a tenderness (often of very small extent) and, by a further manipulation, the appendix itself can many times be mapped out.

The profession at large have not been impressed with the importance of these seemingly unimportant details of palpation and I have frequently observed individuals possessing the greatest mechanical skill in operative surgery, who fairly punched the patient in the belly when examining for appendicitis.

Another very frequent error is to examine with the pulp of the ends of the fingers and an examination, thus made, will leave small grooves in the integument of the abdomen, as evidence of the pressure with the finger nails, which latter cannot reveal anything in this disease. The pulp of the ends of the fingers is not as sensitive as the pulp on the palmar surface of the fingers.

By rubbing the thumb first on the end and then on the palmar pulp this latter fact will be easily demonstrated to anyone.

Fowler (Appendicitis Second Edition 1902, pages 54 and 55) has said that, "Generally speaking, an early and considerable elevation of temperature and rapid pulse rate accompany a high degree of inflammation with tendency to early perforation or gangrene; but the reverse of this is not true. I have known perforation to occur before the formation of protecting walls of adhesions, with a pulse of eighty (80) and a temperature of ninety-nine (99) degrees (Fahrenheit)."

Time after time I have had moribund cases brought to me for operation where several days or even weeks had elapsed since the beginning of the attack. Several of the physicians who brought these cases have said that, in the first place, they were not sure of the diagnosis for the reason that the pain was so slight and not at "McBurney's Point," or the fever was not high and

the pulse rate but slightly accelerated; that the facial expression did not indicate a grave condition or the vomiting, if present, was only slight; that there was not any tympany and that the rectus abdominus muscle was not very rigid. A few of the bacteriologists have said, as an excuse, that there were a normal number of leucocytes.

The general practitioner will diagnosticate, as I have intimated, the typical cases and, usually, this means not appendicitis but some complication such as peritonitis, gangrene or rupture of the appendix, abscess or general peritonitis.

Surgical masters have been laboring strenuously to train the general practitioner how to treat the disease yet, in describing the symptoms of the disease, these same surgical masters have described the symptoms present in some complication of appendicitis and have omitted the information that appendicitis itself has but one invariable sign and that one sign is that of tenderness, which, by careful palpation, may be elicited.

Take a case of a young married woman who four months before had given birth to a robust, healthy child and who, three months after the birth of this child, had a pain in the right illiac fossa. One month later another pain in the abdomen which was relieved by one act of vomiting.

I was called in consultation with the family physician. No history was given me before I entered the patient's room. This young woman received us with a pleasant, happy smile on her face and, cheerfully, gave the short history of her case.

Her temperature was absolutely normal, her pulse rate seventy (70), tongue clear, bowels rather loose, not any pain, abdomen soft. Palpation revealed a tender appendix about one inch below and only slightly to the right of the Umbilicus.

Upon being urged to give my opinion to the patient, I said that here was a case of appendicitis which should be operated upon at once. This same opinion, I then learned, had been given by the family physician who, by the way, is also a skillful surgeon.

Not being satisfied with this, a third medical man was called and gave as his opinion, that, while the patient might be suffering from appendicitis, still the symptoms were so mild that were the patient his sister, he would not consent to an operation.

Two days later a completely disorganized, ruptured appendix was removed by a Deer Lodge surgeon. Fowler (Appendicitis. Second Addition. 1902. Page 58) writes as follows, "The *subacute* variety is not to be looked upon as an innocent form of the disease. Although the febrile action is slight, and the pain and tenderness such as occasion no alarm, these insidious symptoms may be replaced, *without warning*, by those indicating the occurrence of perforation and diffuse septic peritonitis; or the latter may come on without perforation."

Such cases have been observed by me so very frequently that I am of the opinion that the average general practitioner is not sufficiently impressed with the idea of making his diagnosis by palpation alone, and clinching the case for operation on this one sign.

It is a fact that, in the smaller towns, where there is usually, one or more competent surgeons, the deaths following an operation have been and are charged to the operating surgeon and he alone is held responsible. This condition prevails in every section of the United States and it is to place the blame for these deaths where it properly belongs that this paper is written.

It is a matter of fact that hundreds of cases of appendicitis, cholelithiasis and pyloric obstruction have left Montana to go to the so-called surgical centres and there be informed, for the first time, of their real pathological condition when they had previously been treated for biliousness, intestinal indigestion or nervous dyspepsia.

Orbison (The American Journal of the Medical Sciences, Vol. CXXXV. No. 4. April, 1908. Page 562.) in an article, "Neurasthenia of Auto Intoxication," has this to say, "Dr. John Gibbon was consulted. His examination fully upheld the diagnosis and his opinion was that the nature of the obstruction was the presence of adhesions in the appendicular region. We held to this although there was not any history of appendicitis or acute pain in that part of the abdomen."

Orbison gives the after history of this case and reports a cure of the neurasthenia following the removal of the appendix.

In the same article (page 561) it is said, "His condition has been diagnosticated neurasthenia, hysteria, general nervousness and hypochondriasis by competent observers of repute."

When a patient presenting the atypical symptoms of appendicitis and who resides in the smaller cities and towns, is told an operation must be performed, what is the result?

The family physician is called or some friend's family physician is called, and that settles it.

You may just as well stop the boiling of the water. These same men who fail to recognize the atypical cases of appendicitis will say that, it is all very well for you to charge us with not making the diagnosis of appendicitis but, you have not told of the number of operations where a normal appendix has been removed.

In answer to this, I would say that I am going to tell of those cases right now and will begin with the statement, that the number of such cases is very much smaller than you think.

The average medical man knows little about the pathology of appendicitis and, unless one shows pus or gangrene or a ruptured appendix at operation, this average medical man will go home to tell his friends that he saw Doctor So and So remove an appendix which was perfectly normal.

The truth is, however, that that same appendix will, when returned from the pathological laboratory, have a card attached to it and which reads, "A Very Badly Diseased Veriform Appendix."

This man who went home to tell his friends about Doctor So and So removing a normal appendix, did not have his fingers where Doctor So and So had his and, therefore, Mr. Home Going Man could not have seen the kinks and twists which were untwisted and unkinked before the appendix was delivered.

Nor did Mr. Home Going Man notice the remains of the numerous adhesions which were broken up.

You and I are looking at the condition from different angles and I take the view that I do not criticise the fellow who takes the clean appendix out but I do condemn the man who leaves the rotten appendix in.

Ochsner with his treatment and four per cent (4%) mortality and Murphy with his two per cent (2%) mortality in, "General Free Suppurating Peritonitis" are doing harm.

A considerable number of the general practitioners have argued that, if Ochsner beginning his treatment on the cases having been sick for three days and having a four per cent (4%) mortality, then they beginning the treat-

ment on the very first day, will have a mortality not exceeding one per cent (1%).

And, anyway, if there is then any trouble; the patient gets the "Murphy Treatment" including, as it does, the "Fowler Position" and proctoclysis and which only has a mortality of two per cent (2%).

If you surround the surgeons with practitioners, who have eyes in the ends of their fingers, there will not be any need for either the Ochsner or the Murphy treatments.

ARTICULAR RHEUMATISM.*

By Dr. F. J. Patchin, Albuquerque.

May arise from germs closely related and possibly allied to the organisms of scarlatina and of erysipelas.

I had one very severe case follow a mild case of diphtheria. I think these organisms enter the system through the mouth, nose and throat. At least many of the cases that I have treated have shown slight or severe symptoms of these organs previous to the rheumatic attack. We do not know just how they affect the fluids and tissues of the body, especially the nervous function and the vaso-motor apparatus, and the organs of circulation.

We know that the blood, urine and the sweat are modified.

To me the odor of a rheumatic sweat is just as diagnostic of the disease as is the sweat odor of measles or of typhoid fever is diagnostic of those diseases.

The blood contains an excess of fibrin and may contain an excess of lactic acid.

I believe as much in the bacterial origin of Articular Rheumatism as I do in the germ theory of tetany or of meningitis.

I think diathesis or an idiosyncracy as well as other diseases or conditions that lower the vital forces may favor the susceptibility to the inflection just as we contract erysipelas or La Grippe.

I do not think climatic conditions have very much to do with it. Without undue exposure to cold and dampness or fatigue, or improper diet; a lack in keeping the excretory organs performing their proper functions. While the germ theories are in their infancy of development and nature of how they affect the entrance into the human system. We should encourage microscopic research and at the same time we should devote more time in the study of man and his environments, as to diet, sleep, rest, and exercise, and the benefit of sunshine, and how to get away from nervous strain.

Take a new lease on life and you will have a greater resistance to the bacterial inroads to the human system.

Acute Articular Rheumatism

is a self-limited disease lasting, untreated, for about six weeks.

Symptoms.—An elevation of the temperature, acid or sour smelling perspiration, pain, redness, and swelling of the joints, often with effusion. I have observed several cases with nodules of the tendons and faciae, the joints and other structures are rich in white fibrous tissue the joint may be fungacious. Sometimes the disease is ushered in by a chill. In my experience I find nervous, fleshy or stout people more commonly affected. This class of patients are more liable to be constipated and excrete less of the urates and other excreta.

Complications.—The most common is endocarditis (about 25% are pericarditis and myocarditis). The later symptoms are more common to children.

* Read before Bernalillo County Medical Society January 8, 1908.

I have had very few deaths in the twenty-seven years I have practiced medicine caused by rheumatism of the heart. But to the painstaking practitioner who has studied his rheumatic case thoroughly and has progressed fairly well with his case, and there is a sudden rise of two or three degrees of temperature, irregular pulse, palpitation, dyspoea, face cyanotic, and an anxious look you may detect friction sounds.

It is about time the doctor should get anxious and look for a fatal result in twenty-four to forty-eight hours. You will never after fail to watch the heart. The prognosis of this disease is generally favorable.

Unfavorable symptoms are hyperpyrexia, urine low in solids, previous cardiac disease, delirium and coma and relapses.

Treatment.—First is dress. Put patient to bed in flannel gowns open all the way down in front, also between woolen blankets, on woolen pillow slips. A soft but firm woolen mattress or a high, narrow bedstead or cot in a well-ventilated sick room free from drafts of air. The temperature about 75 degrees Fahrenheit. Keep the patient as near absolutely at rest as possible, enveloping all the affected joints in raw cotton, held on by roller bandages. After you have thoroughly applied flannels wrung out of solutions of nitrate or carbonate of potass for half an hour or more, then apply Liniment Aconite Co. or Veratrum Ointment or oil of Gaultheria, then apply cotton and roller bandage. Give Aconite, and Colchicum sem and Salicylate of Sodium to reduce the fever and pain. Would give small doses of some form of mercury.

The Salicylates modify metabolism, the uric acid is increased also is the excretion of the nitrogen and sulphur. I think the Salicylates are the better treatment for young patients, unless complicated by Cardiac symptoms, then the alkalias are indicated. If I had it I would try Menges Serum or the anti-streptococcous serum early in the disease. If obtainable, use glycerine suppositories to evacuate the bowels, or the salines. Ferrum and Quinine; give codien to relieve pain. Would use opiates cautiously; gentle massage. Keep the teeth and mouth and throat clean. Remove any enlarged tonsils. You can do much better surgery with tenaculum or forceps to pick up the base of tonsils between the pillars . Enucleate thoroughly, use alkaline spray to cleanse the nose and throat. Individualize your cases. I can not tell you why alkalias are better for cardiac complications, unless they break up the fibrin and produce anemia.

Diet.—During acute stage, milk or bread and milk, milk toast, buttermilk, skim milk, junket, gruel, and vegetables, cereals and nuts.

The carbohydrates should be restricted just enough to keep up nutrition. Avoid meats of all kinds, and hashes, pickles, sweets and pastry; give plenty of good pure water. Keep this order of diet up for two weeks. Do not give meats until the end of the sixth week, when convalescence begins. Do not forget the *rest* and aboslute rest for the patient and do not forget to examine the heart at each visit. I trust that what I have read will be of some benefit to the busy practitioner in the care of his rheumatic cases, affecting the joints. Other forms or kinds of the disease will be treated under their specific indications.

Don't forget the Roswell meeting, September 15-16, 1909.

NEPHRITIS OR BRIGHT'S DISEASE.*

By Dr. L. G. Rice.

Richard Bright in 1827 discovered that the coincidence of dropsy with albuminuria was referable to inflammation of the kidney; but as the morbid anatomy of the kidney was ill understood at that early date, more or less confusion has resulted in the nomenclature of renal disease, and the other extreme has been reached of attaching too much importance to an elaborate classification.

From a pathological view of the subject there is no better classification than that of Delafield's, with which I hope we are all familiar, but for all practical purposes the clinical classification is the one most suitable for our study tonight, and it is the one I will endeavor to follow. It is more simple but often overlaps the minute classification of morbid anatomy. Some writers would include under the term "Bright's Disease" all renal diseases accompanied by albuminuria, but others include only simple inflammatory and degenerate changes. One of the most serviceable definitions of nephritis, or Bright's Disease, is that emphasized by H. P. Loomis as restricted to all non-suppurative inflammations of the kidney. Every form of inflammation of the kidney involves *all* of its histological structures although in varying degrees. Both kidneys are concurrently involved to very nearly the same degree, and both kidneys may still retain areas of normal structure, a fact which enables them to functionate in spite of disease. The primary cause of all forms of renal inflammation should be regarded as Hematogenous, and hence as beginning through the vascular walls; so we will consider nephritis as a bilateral hematogenous, non-supperative inflammation of the kidney. It is stated by most authorities that we can have albuminuria and casts without nephritis. I contend that we cannot have albumin and casts except mucus casts and cylindroids, without nephritis, but we can have nephritis without albumin or discoverable cast, but even with these rare cases we are generally able to make a diagnosis from other symptoms and the conditions of the urine, such as daily amount, specific gravity, etc.

It has been estimated that eleven per cent of persons examined for life insurance show slight albuminuria without absolutely any other symptoms, and a large percentage of these never develop true nephritis.

As a result of microscopic examinations of over two thousand autopsies statistics of which were made while I was interne in Bellevue less than ten per cent of the subjects over forty years of age had absolutely normal kidneys.

According to the classification I intend to follow, nephritis is divided into acute and chronic forms. Chronic nephritis is again divided into chronic parenchymatous and chronic interstitial types.

Acute Nephritis.

In acute nephritis, the tubular, vascular, and interstitial tissues are simultaneously involved in different degrees in different cases. In the majority of cases the parenchyma, or secreting structure, is the first to become invaded.

Etiology.—The majority of cases occur in children and are caused by the poison of the acute infectious diseases, especially scarlet fever and diphtheria. Other known causes are exposure to cold and dampness when perspiring and exhausted, acute endocarditis, acute aricular rheumatism, typhus, and typhoid fever, pneumonia, malaria, erysipelas, pyemia, jaundice, diabetes, skin diseases, including extensive burns, follicular tonsilitis, pregnancy, injury and

* Read before Bernalillo County Medical Society, February, 1908.

drugs, such as cantharides, turpentine, phosphorus, arsenic, nitrate of silver, operation on kidneys and tuberculosis. lead, mercury, and large quantities of alcohol. It is extremely a rare disease after forty years of age.

Gross Pathology.—The kidney is enlarged, may be twice the normal size, capsule strips off easily, surface is smooth and a mottled appearance due to irregular areas of congestion and anemia. The cut surface is covered with dark red blood but when washed has the same mottled appearance as outside surface.

Symptoms.—They are either sudden or gradual. The sudden consist of a prononuced chill with moderate temperature, dull aching, and tenderness over the kidneys, and prostration. The fever, however, may be absent, the prine is diminished in volume, dark colored, and contains albumin and epithelial and blood casts. If it is not a mild case, or improperly treated, soon extensive oedema shows in the face and extremities, and violent headache, vomiting, delirium, stupor, Cheyne-Stokes breathing, and convulsions usher in uremia. In the gradual form symptoms develop slowly, with mildness until there is an explosion, often initiated by exposure or strain as in parturition, in pregnancy where urine has not been repeatedly examined, the first symptoms may be a uremic convulsion. At first there is headache, nausea, irregularity of bowels, pronounced aneamia, slight increased tension of pulse, urine persistently, dark and high colored, puffiness of lower eyelids on rising in the morning, dyspoea on exertion, general weakness, skin dry and harsh, no fever. These symptoms improve or uremic attacks may supervene, as above mentioned. About ten per cent become chronic.

Diagnosis.—This is ordinarily quite easy, with a history of the case and a urine examination there should be no difficulty whatever. It is interesting sometimes to know if it is an acute exacerbation of a chronic nephritis. This can be readily decided where we have a history of the case and there is hypertrophy of left ventricle with a marked accentuation of second sound and a high tension pulse. It is also interesting in convulsions of pregnancy to know if the condition is due to acute nephritis or toxemia of pregnancy. I consider all such uremic conditions in pregnancy, without fever, due to acute nephritis caused by the toxemia of pregnancy, which is demonstrated by autopsy findings, but we know very little about the kidney of the non-fatal or mild cases, nevertheless it does not alter the treatment in the least where uremic symptoms are present, except in the latter condition we should empty the uterus at once.

Treatment.—Preventative. A few years ago cure claimed most of our attention, was most sought, while prevention played a minor part. At the present day, while we abate in no way our search for a cure, prevention has come to the front and has of late probably been far more successful in checking the ravages of the disease. During and for some time after the diseases enumerated as causes we should study the pulse closely and make frequent examinations of the urine for it has been said that a brisk purge of something no stronger than compound jalap powder will prevent acute nephritis, if given in time. The amount of nitrogenous food should be diminished to a minimum, elimination should be aided by improving condition of bowels, kidneys, liver, skin and lungs. Keep patient in bed properly clothed until danger period is passed. In most cases we have to deal with the developed disease, our first endeavor should be absolute rest, warmth

and a suitable diet such as milk and vichy, or milk and lime water and in mild cases this is all that is necessary. Where there is much local distress or suppression of urine, pacquelin cautery, dry cupping or poultiecs should be used. Temporary or partial physiological rest for the kidneys is obtained by promoting activity of skin and intestines. The skin can be kept active by the use of the hot water bath, hot steam bath, hot air bath, or hot wet pack. I prefer the wet pack which is not so liable to produce faintness, in conjunction with this we should use hot drinks. If a dose of sweet spirits nitre and a little ipecac is given previous to the pack better results will be obtained. If more active measures are called for some of the preparation of Joborandi should be used. Pilocarpin, its active principal, should be used with caution and rarely ever given to children. After this treatment has been carried out we naturally look for some drug to increase the amount of urine and decrease the dropsical condition. There is nothing better than digatalis if we are careful to get a reliable preparation. I prefer the infusion in large doses often repeated until a decided effect is produced on pulse, then diminish dose of digitalis and use in conjunction a mixture of acetate, citrate, and bitartrate of potassium which will add water to the blood and keep kidneys flushed out.

Where the condition becomes one of uremia our treatment should be along the same line, but a little more energetic. The mistake is often made of being too heroic in our use of drugs. Use chloroform for first aid to control convulsions, use Croton oil or elaterium, two drops of the former, or one-quarter of a grain of the latter. Inject a dram of chloral hydrate in solution, high into rectum. Give one-third grain pilocarpin hypodermically to be repeated in half an hour if necessary. Put patient in a hot wet pack, and if convulsions continue after this treatment blood letting, transfusion, or hypodermoclysis should be performed. Morphine hypodermically in one-half grain doses is permissible in acute nephritis where there is no history of chronic nephritis. Elevate foot of bed and give almost continuously high hot saline enema, temperature 110 F. If the case is complicated by pregnancy empty uterus at once and give viratrum vide, dose of which is 10 to 20 minims.

To shorten this paper I have omitted everything in regard to the chronic forms except the treatment.

Treatment of Chronic Nephritis.

Preventative Treatment. — In both forms the cause is an irritant acting on the renal cells. In order to remove the irritant we must know what it is. Unfortunately it is often undiscoverable As we prevent the acute infectious diseases from occurring and are prompt in their successful treatment, we therefore eliminate a large number of cases of nephritis, after these comes alcoholic excesses and excessive eating and indulgences in strong tea and coffee in large quantities.

Curative Treatment. — A keener judgment is required to treat a chronic case, for many need nothing but the withdrawal of the cause with proper hygienic and dietic management, but we should advise these mild cases against exposure, fatigue, and overwork, to retire early and seek abundance of rest. Eat in moderation. Drink a moderate amount of fluids between meals, abstain from alcoholic drinks of all kinds, and remember in regard to foods it is more a matter of quantity than quality. A nightly warm bath with friction is a good procedure just at bed time.

In regard to the medical treatment directed to the kidney there is no drug

which will create new renal cells for those that have been replaced by connective tissues. One principal object must be to save the kidney from further irritation or destruction. Even in mild cases there is generally a tendency to anemia, which requires the administration of iron, but this remedy is too carelessly administered and often does more harm than good by causing constipation and locking up other secretions. Iron should be given in small doses in combination with a very small dose of bichloride of mercury well diluted. A regular sufficient action of the bowels is very essential. Purgatives acting on the liver are especially serviceable. To this end a weekly or bi-weekly dose of calomel is suitable. The iodides dilate the blood vessels and facilitate the onward movement, hence is an excellent remedy for almost constant use in many cases of chronic nephritis. Where there is much albumen and many casts and a more decided diuretic is called for theocin or diuretin generally works nicely. In the conditions where we have a very high tension pulse in conjunction with this treatment we should use nitroglycerine. Where we have a tendency to cardiac failure we should also use strychnine and digitalis or strophanthus.

Dr. Edebohl and others have had some excellent results from the operation of decapsulation for the cure of chronic Bright's disease. This operation should be performed in the chronic interstitial type.

Again wishing to shorten my paper I have said very little about special diet and climatic conditions, albuminuric retinitis, renal headaches and many other complications of chronic nephritis.

Don't forget the Roswell meeting, September 15-16, 1909.

OVERDOING THE POISON LABEL CAUTION.

It is perfectly proper for the protection of the public that real poisons, when they go out from the drug store, should be labeled as such, as is provided for by the laws of all of our states. But there is great danger that this salutary caution may be carried to such an extreme as to defeat the very end it aims at. For instances, the bill introduced by Congressman Mann in the House of Representatives contains a long list of drugs, including practically all chemicals to be found in the drug store, which, when they or their derivatives, or preparations containing same in even the smallest quantity, are dispensed or sold, must bear a label with the word "Poison" printed in large type in white on red background, or in red on white background, together with the skull and cross-bones device.

This means that if ever so small a quantity of paragoric, for instance, is contained in a mixture, the said mixture must have the scare label as if it were a really virulent poison.

As we have said, such a law will be apt to defeat its own purpose, for the reason that, when the people find the skull and cross-bones device and the poison label on practically every medicine, they will become so familiar with it, that its effectiveness as a warning will be entirely lost, and many lives may be sacrificed in consequence.

Indeed, just such a result has followed similar extreme legislation in Russia. In that country the laws provide that the poison label shall be attached to a large number of substances, among which is the popular alcoholic drink Vodka. As an immense amount of this beverage is consumed, the poison label, instead of serving its purpose as a warning, finally, with the illiterate population, became identified with the

drink itself, with the consequence that really poisonous mixtures and substances, which also, of course, bore the poison label, were drunk by these people, under the impression that any bottle bearing the poison label contained Vodka.

That results similar in their consequences would follow the overdoing of the poison label business in this country is certain. With the poison label the saying that "familiarity breeds contempt," most aptly applies and if it appears on all medicines it will cease to attract any attention. We trust, therefore, that our legislatures, under the idea that they are protecting the people, will not commit the mistake of making the skull and cross-bones device so common that it will no longer serve as a caution.—National Druggist.

DAILY PRESS AND MAGAZINE ITEMS.

Rudyard Kipling to Doctors.

From the Newark Evening News, April 21, 1909.

Rudyard Kipling distributed the prizes at the Middlesex Hospital and delighted his audience with a characteristic speech, writes a London correspondent of The Medical Record. He remarked that it might have escaped their professional observation that there were only two classse of mankind —doctors and patients. He had felt a delicacy in confessing he belonged to the latter ever since a doctor told him that all patients were great liars where their own symptoms were concerned. The average patient might regard the doctor as the non-combatant does the troops who fought for him. He had to address the army which is always fighting against death. It was unfortunate that death was bound to win in the long run. This fight is one of the most important things in the world and you who carry it on, he said, must be among the most important people. The world certainly insists on this. It long ago decided you have no leisure that any one need respect.

Nothing but extreme illness can excuse you in its eyes for refusing help to anyone who thinks he needs you at any hour of the day or night. Nobody will care whether you are in your bed or in your bath—at church or a theatre. What vitality you have accumulated in your leisure will be dragged out of you again. In time of plague, pestilence, fire, battle, famine, murder and sudden death it is required of you to go on your duty at once and stay till your strength fails or your conscience relieves you, whichever be the longer period.

These are some of your obligations and not likely to grow lighter. Have you heard of any eight-hour bill for doctors? Do you know of any change in public opinion that will allow you to refuse to attend a patient who does not mean to pay? Have you heard any outcry against people who can well afford to pay but prefer to cadge around a free hospital and get advice, glass eyes and cork legs for nothing? I have not. It is required of you to save others at all moments. It is nowhere laid down that you must save yourselves.

You have been and always will be exposed to the contempt of the gifted amateur, the gent who knows by intuition everything that has cost you years of study. You have also been and always will be exposed to the attack of those persons who consider their own undisciplined emotions more important than the world's most bitter agonies—the people who would hamper and limit and cripple research because they fear that it may be accompanied by a little pain and suffering. Such people have been against you from the beginning, ever since the earliest Egyptians erected images in honor of cats and dogs on the banks of the Nile. But your work will

go on. You remain perhaps the only class that dares tell the world that no man can get more out of a machine than he puts into it, and that if the fathers have eaten forbidden fruit the children's teeth will be set on edge.

In a day when few things are called by their right names you are joining a profession in which it pays to tell the truth. Realizing these things, I need not task your patience by talking about the high ideals and lofty ethics of that profession—so I will wish you enough work to do and strength to do the work.

Next meeting at Roswell, September 15-16, 1909.

WHEN MOMENTS ARE GOLDEN. "A RADICAL REMEDY FOR TUBERCULOSIS." DEATHS.

There are times in the experience of every practitioner when moments are precious—emergencies when there is not an instant to lose. A patient, let us say, is writhing in pain. To alleviate his suffering the physician must act promptly and with precision. Dependence in such a crisis, is usually upon a single little hypodermatic tablet. And that tablet, will it justify the faith? It is *medicinally active?* Is it *of full strength?* Is it *soluble?* These become living questions.

Too much stress cannot be laid upon the importance of solubility. And let it be remembered that flying to pieces in water is not the requirement. Many tablets do that—fine, undissolved particles settling to the bottom. This is mere disintegration, not solution; and such a tablet cannot be depended upon to yield the results that the practitioner desires and expects.

Obviously, the physician should exercise care in choosing his hypodermatic tablets. Let his source of supplies be a house with a reputation for making tablets that are stable, active and of uniform strength; tablets that *dissolve promptly and completely.* Let him search out a brand of hypodermatic tablets that meet all of the requirements above set forth, and let him specify that brand.

The largest manufacturers of hypodermatic tablets in the world are Parke, Davis & Co. The hypodermatic tablets of this house are true to label. They are soluble. The materials entering into them are rigidly tested for purity and activity. Parke, Davis & Co.'s hypodermatic tablets are thoroughly trustworthy. Physicians will make no mistake when they specify them on their orders.

"A RADICAL REMEDY FOR TUBERCULOSIS."

The letter printed below was received by a patient of one of our editors, and save for the omission of names and date is a true copy of the original.

Dear sir my Remedy is to Inhale Cloriform allmost every Hour in the day Have you a botol of Chloroform in your Pocket & smell it every Hour until it makes your fingers tingle then stop a while ½ to 1 Hour and then go though withe same again get the best *Chloriform* Give the Patient

R	Quinine	1 ounce
	Carbonate of Iron	1 ,,
	Cream of Tarter aa	1 ,,

M and take a No. 2 capsule 3 times a day also use Dr King New Discovery to controle the cough.

Comment on the above is unnecessary. The treatment is not recommended for general use, however.

Next meeting at Roswell, September 15-16, 1909.

The following extract from the New York State Journal should be read by every physician who has anything to do with the X-ray or with fractures. We believe that this knowledge should be spread among the laity since it is amusing to find the popular notion concerning this agent.

Nine individuals out of ten believe that the X-ray will show anything in the tissues, be it a cannon ball or a broken nerve.

Kathan voices a warning in the following words:

"That there has been much damage done to patients exposed to the X-ray by careless and incompetent operators, there is much evidence to prove. That there is no danger in the hands of a trained operator is equally well established.

That the skin and subcutaneous tissues suffer if exposed too long to these rays, or are brought into too close proximity to the tube, is doubtless true. Too frequent short exposures have the same injurious effect as one long exposure. Nor is it sufficient for the operator to be able to give us a radiograph clear and well defined, but he must be able to interpret correctly the findings thereof.

A radiograph is not a picture of the part exposed, but a shadow thereof. A shadow does not always correctly represent the object which casts it. It may be larger or smaller than the object, depending upon the relative size and distance of object and light. These rays are not parallel, but divergent, so that fractures displaced are exaggerated, and the distance between fragments are likely to appear greater than they really are. Hence the necessity for a trained radiologist is obvious.

In simple fractures a fluoroscope may be sufficient, but it is not so reliable as a plate. The plea that fluoroscope is a great saver of time is no longer valid, as the plate can be ready for inspection within ten minutes after exposure, and this besides being more reliable, we can study at leisure and is a matter of permanent record."

Next meeting at Roswell, September 15-16, 1909.

A NEW CALENDAR.

We have received from a California enthusiast a scheme for revising the calendar, which is logical, easy and wholly satisfactory. Therefore, we conclude that it will not be adopted. He wants it put into effect January 1, 1911, as it won't be available again for eleven years. The plan is to make a year of 13 months of 28 days each, placing an extra month, "Vincent," between June and July, and to make the last day of the year, the 365th, "Anno Day" or practically a dies non for all ordinary purposes. According to this plan the first day of every month would be Sunday, as would the 8th, 15th and 22d. Every day of the week would fall on a fixed series so that it would be easy to figure out; in fact, to a large extent, it is adopting the nomenclature of the Friends in this respect. On leap years an extra anno day would be inserted between the 14th and 15th Vincent, and also would be a dies non as it would fall between Saturday and Sunday.—Philadelphia Inquirer.

MADE HIM SICK.

"Have you ever been ill on shipboard?"

"Yes, I lost $100 playing poker in the smoking room yesterday."—The Bohemian.

Next meeting at Roswell, September 15-16, 1909.

BOOKS RECEIVED.

The Opthalmic Year Book, for 1909.

Transactions of the Florida Medical Association, for 1909.

"Confiscatory Legislation," a pamphlet issued in the interests of the American Proprietary Association, and containing "Confession by Colliers Man," the "Doctors Trust," etc. Also a clipping from the National Druggist for March containing an article entitled "A Leading A. M. A. Official in Disgrace." This article attacks our friend, Dr. Chas. A. L. Reed, of Cincinnati, Chairman Committee on Medical Legislation, A. M. A.

"Manual of Therapeutics," for 1909; issued by Parke, Davis & Company, Detroit, Michigan.

"Public Care and Treatment for the Epileptic," a pamphlet issued by the National Association for the Study of Epilepsy and the Care and Treatment of Epileptics, Sonyea, New York.

"Tuberculosis, A Preventive and Curable Disease," by S. Adolphus Knopf, New York. With 115 Illustrations. 8vo, $2.00 net. Moffat, Yard & Company, Publishers, New York.

Transactions of the American Proctological Society, Eleventh Annual Meeting, Atlantic City, June 7-8, 1909.

Reprint—The Anatomical Basis for Successful Repair of the Female Pelvic Outlet by Irving S. Haynes, Ph. B., M. D., New York.

Report of the Citizen's Health Committee of San Francisco, relative to the Eradication of the Bubonic Plague.

Report of the Committee on Social Betterment of the President's Homes Commission, including Report of the Committee on Building of Model Houses, by Gen. Geo. M. Sternberg, M. D., LL. D.

Industrial and Personal Hygiene, by Geo. M. Korber, M. D., LL. D.

Report of the Committee on Improvement of Existing Houses and Elimination of Unsanitary and Alley Houses, by William H. Baldwin, Chairman.

Report of Committee on Social Betterment, by Geo. M. Korber, M. D., LL. D.

PLANS TO STEAL COW A THIRD TIME.

Sam Kirk, soon to be released from the Frankfort (Ky.), penitentiary, is serving his second term for having stolen the same cow twice. He announces that as soon as he gets out he will make another try for the cow if it is still living, as he holds it responsible for his two-year sentence. He never did anything wrong except steal that cow.

An Improved Form of Mercury for Inunction

Metallic mercury in a state of minute subdivision, incorporated in a cacao-butter base and compressed into little oblong blocks, each block wrapped in wax tissue and tinfoil, and containing 30 grains of metallic mercury and 60 grains of pure cacao-butter.

MERCURETTES

are superseding the old-fashioned blue ointment—for these very good reasons:

Blue ointment is unsightly in appearance. **Mercurettes** suggest elegance.

Blue ointment has an unpleasant odor. **Mercurettes** are agreeably perfumed.

Blue ointment often becomes rancid with age. **Mercurettes** keep indefinitely.

Blue ointment cannot be applied with any accuracy of dosage. **Mercurettes** contain a definite amount of mercury. One or two may be prescribed, or a tablet may be divided into two or more parts if desired.

Test **Mercurettes** in your practice. You will be pleased with them.

Supplied in boxes of 6.

Container and Dropping-Bottle Combined

THE CHLOROFORM DROPPER-AMPOULE

is at once a hermetically-sealed container and a perfect dropping-bottle. It supplies in portable form enough of the anesthetic for one service—about 30 grammes of **Parke, Davis & Co.'s Pure Chloroform.** It is economical—loss by evaporation, spilling and deterioration being practically eliminated. It is conveniently carried in the medicine-bag. It is always ready for use. The physician has merely to break off the capillary point of the long tube, also the capillary point on the shoulder of the ampoule, with thumb-nail, knife-blade or forceps. The chloroform flows in drops.

Our Dropper-Ampoule is the most practical chloroform package on the market to-day.

Fig 1


Fig 2

PARKE, DAVIS & COMPANY

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